

# EMERGENCY MEDICAL AUTHORIZATION

(As mandated by House Bill 639)

## OLMSTED FALLS SCHOOLS

Check box if new address  
since last  
school year

**PURPOSE** -to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

STUDENT NAME: \_\_\_\_\_ TELEPHONE: (\_\_\_\_) \_\_\_\_\_ BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
PLEASE PRINT IN INK (LAST) (FIRST) MO. DAY YR.

ADDRESS: \_\_\_\_\_  
(STREET) (APT. #) (CITY) (ZIP CODE)

SCHOOL: \_\_\_\_\_ BUS #: \_\_\_\_\_ GRADE: \_\_\_\_\_ RM #: \_\_\_\_\_ TEACHER: \_\_\_\_\_

### Custodial Parent or Guardian

Mother's Name (Residential): \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_

Father's Name (Residential): \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_

Other's Name: \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_

### Friend, Relative, or Childcare Provider

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_  
(STREET) (CITY) (ZIP)

**\*If any of the above information changes during the school year, please inform the main office.\***

### PART I OR II MUST BE COMPLETED

#### PART I - TO GRANT CONSENT

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Local Hospital: \_\_\_\_\_ Emergency Room Phone: \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred physician is not available, by other licensed physician or dentist; and (2), the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Please list in the space below facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent / Guardian:

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

I would like this information included on a confidential health concern list that would be distributed to school personnel.  
Please circle your response:      yes      no

#### PART II - REFUSAL TO CONSENT

(Do **not** complete if you completed Part I)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the authorities to take the following action:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent / Guardian:

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_